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Newsroom

Annual Limits Policy: Protecting Consumers, Maintaining Options, and Building the Bridge to 2014

In 2014, the Affordable Care Act will ensure all Americans have access to high-quality, affordable, and comprehensive health insurance plans that cannot include lifetime or annual dollar limits on benefits.

To implement the ban on restrictive annual limits before 2014, most insurance plans began phasing out their annual limits in September 2010. Millions of Americans are now in plans that cannot impose annual limits below $750,000, and that limit will increase in the coming years until 2014 when no annual dollar limits will be permitted for non-grandfathered plans. The law also restricts the sale of new plans with low annual limits except under very limited circumstances.

Protecting Worker's Coverage

A small number of workers and individuals only have access to limited benefit, or "mini-med," plans with lower annual limits than are generally permitted by law and which can provide very limited protection from high health care costs. Employers and insurers estimated that requiring mini-med plans to comply with the new rules could cause mini-med premiums to increase significantly, forcing employers to drop coverage and leaving some workers without even the minimal insurance coverage they have today.

In order to protect coverage for workers in mini-med plans until more affordable and more valuable coverage is available in 2014, the law and regulations issued on annual limits allow the Department of Health and Human Services (HHS) to grant temporary waivers from this one provision of the law that phases out annual limits if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. Plans that receive waivers must comply with all other provisions of the law and must alert consumers that the plan has restrictive coverage and includes low annual limits. Additionally, these waivers are temporary and after 2014, no waivers of the annual limit provision are allowed.

On June 17, 2011, the Centers for Medicare & Medicaid Services (CMS) introduced a process for plans that have already received waivers and want to renew those waivers for plan or policy years beginning before January 1, 2014. The new guidance extends the duration of waivers that have been granted through 2013, if applicants submit annual information about their plan and comply with requirements to ensure that their enrollees understand the limits of their coverage. Existing waiver recipients must apply to extend their current waiver and all applications must be submitted by September 22, 2011; after that date applications for an extension will no longer be considered. Any plans that have not yet applied for a waiver also must apply by September 22, 2011.

Plans with low annual limits (e.g., $10,000) are most likely to need waivers to prevent a significant increase in premiums or decrease in access to coverage to comply with the current limit of $750,000. Many of these plans have already received a waiver. Plans with higher annual limits are less likely to

qualify for a waiver because complying with the new rules is unlikely to lead to a significant increase in premiums or decrease in access to care. Still, the policy announced today gives all plans and issuers with restricted annual limits below $2 million a reasonable opportunity to apply for a waiver.

Increasing Transparency for Consumers

The Affordable Care Act includes consumer protections that that will require plans, particularly mini-med plans, to give consumers more information about their health insurance plans. Health insurers offering mini-med plans must notify consumers in plain language that their plan offers extremely limited benefits and direct them to www.HealthCare.gov where they can get more information about other coverage options.

The new guidance issued on June 17, 2011 imposes more stringent disclosure requirements and requires a new version of this consumer notice that will make the information easier for families to understand. Health plans with waivers must tell consumers that their health care coverage is subject to an annual dollar limit that is lower than what is required under the law. Specifically, the yearly notice must include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies. Plans must illustrate how the annual limit would impact a consumer who was hospitalized, so families can understand how far their coverage will reach if they become seriously ill. To do so, the updated model notice compares a policy's annual limit with examples demonstrating the average cost of night's stay in the hospital. Plans with waivers must attest annually to their compliance with the consumer disclosure requirement.

Phasing Out Annual Dollar Limits

Until annual dollar limits are banned for non-grandfathered plans beginning in 2014, insurers and plans must phase out the use of annual dollar limits on essential health benefits. Today, most plans cannot impose an annual limit that is less than $750,000. That limit will increase to $1.25 million for plan years starting after September 23, 2011 and to $2.0 million for plan years starting after September 23, 2012. No annual dollar limits are permitted with respect to plan or policy years beginning on or after January 1, 2014, except in the case of grandfathered individual market policies.

On September 3, 2010, HHS issued the original guidance laying out the waiver process requiring

plans to demonstrate that complying with a $750,000 annual limit would cause a significant increase in premiums or a significant decrease in access to benefits. This process has ensured that 3.1 million Americans – about 2 percent of people with private insurance – have been able to keep their health coverage during the transition to 2014. The new guidance extends the duration of waivers through 2013, if applicants submit annual information about their plan and comply with disclosure requirements. Existing waiver recipients may apply for an extension of their current waiver, and all applications must be submitted by September 22, 2011. After September 22, 2011, no application for extension will be considered.

Some existing plans have annual limits above $750,000, but below $2 million. Actuarial analysis suggests that plans can meet the increased annual limit of $1.25 million with just minimal premium increases (less than one percent). Similarly, increasing annual limits from $1.25 million to $2 million the following year will have a small impact on premiums. It is therefore unlikely that these plans will qualify for a waiver to comply with the annual limit policy. However, if the circumstances of a particular plan indicate that it will need a waiver from these requirements to prevent a significant increase in premiums or decrease in benefits, the plan can apply for a waiver before September 22, 2011.